

Penny Joss Fletcher, M.A.

Licensed Marriage and Family Therapist
Individual and Marital Psychotherapy
Infertility and Adoption Counseling
515 E. First St., Suite D
Tustin, CA 92780
(714) 730-7996
www.infertility2adoption.com

Welcome to the office of Penny Joss Fletcher. In an attempt to establish a smoothly running office system and a professional relationship with my clients, I have developed the following policies and procedures. I ask that you read and sign this information sheet in order to ensure your understanding and willingness to abide by the policies as established. Please do not hesitate to ask questions, and thank you in advance for your cooperation.

1. It is my understanding that you have been referred to my office in preparation for a third party reproduction treatment cycle. We will meet for a psycho-educational counseling session to provide you with information about what to expect, and to confirm that you are ready and informed to continue with the cycle.
2. The session will take approximately 1 hour. I will then write a narrative report which will be sent to your physician. If I have any concerns about you proceeding with the treatment cycle, I will share them with you at the end of the session and with your physician in my report. I am not a gatekeeper and cannot cancel your cycle.
3. Payment is to be made at the time of the appointment. The fee for the counseling session and the report is \$200.00. Insurance will not pay for this session and report.
4. Should you wish to enter into a therapeutic relationship with me, the following procedures would apply: Sessions are 50 minutes in length in order to allow me to complete paperwork, return phone calls, and effectively “switch gears” from one client to the next. Overtime or phone consultation time is billable in 15 minute intervals. I would appreciate it if you would fill out your check before the session begins, made payable to “Penny Joss Fletcher”, so as to maximize your valuable session time.
5. Payments are to be made at the time of each appointment which include insurance co-payments and unmet deductibles. The fee for Individual, Marital/Conjoint and Family Therapy is \$100.00 per session. Please talk to me about your financial situation if necessary or if you wish to utilize insurance coverage.
6. In order to cancel or change an individual, marital, family or phone appointment, you must notify me at least 24 hours prior to the scheduled appointment. My voice mail handles calls 24 hours/day when I am not in the office. If proper notice is not received, you are responsible for payment for the missed session. Insurance cannot be billed for late cancellation or missed sessions.

I have read, understood, and agree to the above policies of Penny Joss Fletcher, M.A., MFT.

Signature _____ Date: _____

INTAKE FACE SHEET

The requested information becomes part of your file and is confidential. Please print.

Wife's Name _____ Home Phone () _____

Husband's Name _____

Home Address _____

(number and street)

(city)

(state)

(zip code)

Wife's Date of Birth _____

Cell Phone () _____

Email Address _____

Husband's Date of Birth _____

Cell Phone () _____

Email Address _____

Wife Employed by _____ Business Phone () _____

May we call you at work? _____

Business Address _____

(number and street)

(city)

(state)

(zip code)

Wife's Social Security #: _____ Husband's Social Security # _____

Husband Employed by _____ Business Phone () _____

May we call you at work? _____

Business Address _____

(number and street)

(city)

(state)

(zip code)

Referred by: _____

In case of EMERGENCY contact:

Name: _____

Address: _____

(number and street)

(city)

(state)

(zip)

Home Phone: _____ Business Phone: _____

Date: _____

CONFIDENTIAL BACKGROUND INFORMATION FORM - WIFE

Please print.

Age _____ Educational Level _____ Occupation _____

Marital Status _____ Years Married _____

of Pregnancies: _____ # of Children _____ Names & Ages of Children _____

Previous counseling _____
(name/names) (how long)

If you are currently under the care of a physician, please provide information:

Physician's Name: _____ Physician's Telephone: _____

Date of last physical _____ Results _____

Hospitalization _____
(reason) (how long)

Medication _____
(what kind/dosage/prescribed by)

(condition being treated by medication)

Current chronic conditions _____

Family history of medical problems _____

of Siblings _____ What sibling position are you? _____

Parents: Are they still married, divorced, deceased? _____

Is either parent remarried? _____

Describe your mother _____

Describe your father _____

Persons living with client _____

Relationship/marital history _____

Raised in what religion: _____ Present religion: _____

CONFIDENTIAL BACKGROUND INFORMATION FORM - HUSBAND

Please print.

Age _____ Educational Level _____ Occupation _____

Marital Status _____ Years Married _____

of Pregnancies: _____ # of Children _____ Names & Ages of Children _____

Previous counseling _____
(name/names) (how long)

If you are currently under the care of a physician, please provide information:

Physician's Name: _____ Physician's Telephone: _____

Date of last physical _____ Results _____

Hospitalization _____
(reason) (how long)

Medication _____
(what kind/dosage/prescribed by)

(condition being treated by medication)

Current chronic conditions _____

Family history of medical problems _____

of Siblings _____ What sibling position are you? _____

Parents: Are they still married, divorced, deceased? _____

Is either parent remarried? _____

Describe your mother _____

Describe your father _____

Persons living with client _____

Relationship/marital history _____

Raised in what religion: _____ Present religion: _____

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LIMITS OF CONFIDENTIALITY

The psychotherapeutic relationship and all client records are confidential. No client information will be given out without your written permission with the following exceptions:

- **ABUSE:** If you tell me that you have been mentally, physically or sexually abused as a minor, elder or a dependent adult, or if you indicate that you have in any way been involved in, or have knowledge of anyone being involved in any of the above referenced abuses to a minor, an elder or a dependent adult, I am required by California law to report this information to appropriate legal agencies.
- **THREAT OF HARM TO SELF OR ANOTHER:** Section 1024 of the Evidence Code of the State of California requires me to break confidentiality if I have reasonable cause to believe that a client is in such mental or emotional condition as to be dangerous to her/himself or to the person or property of another.
- **COURT ORDER:** Upon advise of counsel, I will comply with any lawful court order to release information about your contact here.
- **INSURANCE COMPANIES, EAP'S AND MANAGED CARE COMPANIES:** Most authorizing agents of your insurance benefits will require information such as diagnosis, treatment goals and plans, symptoms, mental health and chemical dependency history. This information does not go to your employer.
- **CONJOINT COUNSELING:** When working interchangeably with individual and conjoint sessions, information from individual sessions will not be given out in conjoint sessions.

I DECLARE THAT I HAVE READ AND UNDERSTAND THE ABOVE LIMITATIONS OF CONFIDENTIALITY AND AGREE TO ITS CONTENTS.

Signed: _____ Dated: _____

Signed: _____ Dated: _____

Witness: _____ Dated: _____